

COMMUNITY, HOUSING AND

HUMAN SERVICES DEPARTMENT

808 W. SPOKANE FALLS BLVD

SPOKANE, WA 99201

**COMMUNITY, HOUSING AND HUMAN SERVICES (CHHS) DEPARTMENT**

***NEW PROJECT APPLICATION***

**2018 CONTINUUM OF CARE (CoC) PROGRAM COMPETITION**



**Department of Housing and Urban Development (HUD)   
Continuum of Care Program**

|  |
| --- |
| The Continuum of Care (CoC) Program is designed to promote communitywide commitment to the goal of ending homelessness; provide funding for efforts by nonprofit providers, and State and local governments to quickly rehouse homeless individuals and families while minimizing the trauma and dislocation caused to homeless individuals, families, and communities by homelessness; promote access to and effect utilization of mainstream programs by homeless individuals and families; and optimize self-sufficiency among individuals and families experiencing homelessness. |

**July 6, 2018**

Contents

[Application Instructions 2](#_Toc518624767)

[Agency Information: 3](#_Toc518624768)

[Experience of Applicant and Other Partners 4](#_Toc518624769)

[Project Detail 4](#_Toc518624770)

[Supportive Services for Participants 6](#_Toc518624771)

[Housing Type and Location 8](#_Toc518624772)

[Project Participants - Households 9](#_Toc518624773)

[Project Participants – Subpopulations 9](#_Toc518624774)

[Outreach for Participants 10](#_Toc518624775)

[Budget 11](#_Toc518624776)

# Application Instructions

Complete all applicable questions. If you have any questions, please contact the RFP Coordinator. You are required to complete this general application, the housing first assessment, and budget documents. Reference the RFP for a complete list of additional attachments, such as policies and procedures and match letter requirements before submitting your complete application packet.

# Agency Information:

Organization Name:

Organization Type: Choose an item.

Employer or Tax Identification Number:

Organizational DUNS: PLUS 4:

Physical Address:

Street:

City:

State:

ZIP Code

Is your organization a Faith-Based Organization? Choose an item.

Has the agency ever received a federal grant, either directly from a federal agency or through a State/local agency? Choose an item.

**Contact Person**

First Name:

Middle Name:

Last Name:

Title:

E-mail Address:

Confirm E-mail Address:

Phone Number:

Extension:

Fax Number:

# Experience of Applicant and Other Partners

1. Describe the experience of the subrecipient(s), in effectively utilizing federal funds andperforming the activities proposed in the application, given funding and time limitations.
2. Describe the experience of the agency in leveraging other Federal, State, local, and private sector funds.
3. Describe the basic organization and management structure of the agency. Include evidence of internal and external coordination and an adequate financial accounting system.

# Project Detail

1. Project Name:
2. Component Type: **Joint TH-RRH**
3. Does this project use one or more properties that have been conveyed through the Title V process?
4. Provide a description that addresses the entire scope of the proposed project.
5. For each primary project location or structure in the project, enter the number of days from the execution of the grant agreement that each of the following milestones will occur as related to CoC Program funds requested in this project application. If a milestone is not applicable, leave the associated fields blank. If the project has only one location or structure, or no structures, complete only column A. If multiple structures, complete one column for each structure.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Project Milestones** | | | | |
|  | Days from grant agreement execution | Days from grant agreement execution | Days from grant agreement execution | Days from grant agreement execution |
| New project staff hired, or other project expenses begin |  |  |  |  |
| Participant enrollment in project begins |  |  |  |  |
| Participants begin to occupy leased units or structure(s), and supportive services begin |  |  |  |  |
| Leased or rental assistance units or structure, and supportive services near 100% capacity |  |  |  |  |
| Closing on purchase of land, structure(s), or execution of structure lease |  |  |  |  |
| Rehabilitation started |  |  |  |  |
| Rehabilitation completed |  |  |  |  |
| New construction started |  |  |  |  |
| New construction completed |  |  |  |  |

1. Will the project use an existing homeless facility or incorporate activities provided by an existing project?
   1. If “YES” to question 6, complete the following question: Is this New Project Application requesting a “Project Expansion” of an eligible renewal project of the same component type?
   2. If “YES” to question 6a, complete the following questions:
      1. Eligible Renewal Gran Number:
      2. Eligible Renewal Grant Project Name
      3. Select the activities below that describe the expansion project: (select all that apply)

Increase the number of homeless persons served

Provide additional supportive Services to homeless persons

Bring existing facilities up to state/local health and safety standards

Replace the loss of nonrenewable funding (private, federal, other excluding state/local government)

Coordinated entry

1. Will your project participate in Coordinated Entry? Choose an item.
2. Please identify the project's specific population focus: (select all that apply)

Chronic homeless

Veterans

Youth (under 25)

Families

Domestic Violence

Substance Abuse

Mental Illness

HIV/AIDS

Other:

1. Will the project quickly move participants into permanent housing? Choose an item.
2. Does the project ensure that participants are not screened out based on the following items? (Select all that apply)

Having too little or no income

Active history of substance use

Having criminal record with exceptions for state-mandated restrictions

History of victimization (e.g. domestic violence, sexual assault, childhood abuse)

None of the above

1. Does the project ensure that participants are not terminated from the program for the following reasons? Select all that apply.

Failure to participate in supportive services

Failure to make progress on a service plan

Loss of income or failure to improve income

Any other activity not covered in a lease agreement typically found for unassisted persons in the project’s geographic area

None of the above

1. Will the project follow a “Housing First” approach? Choose an item.
2. If applicable, describe the proposed development activities and the responsibilities that the agency (if any) will have in developing, operating, and maintaining the property.
3. Will participants be required to live in a particular structure, unit, or locality, at some point during the period of participation? Choose an item.
4. Will more than 16 persons live in one structure? Choose an item.

# Supportive Services for Participants

1. Applicants requesting funds to provide housing or services to children and youth, with or without families, must establish policies and practices that are consistent with and do not restrict the exercise of rights provided by subtitle B of title VII of the McKinney-Vento Act (42 U.S.C. 11431, et seq.), and other laws (e.g. Head Start, part C of the Individuals with Disabilities Education Act) relating to the provision of educational and related services to individuals and families experiencing homelessness. Projects serving households with children or youth must have a staff person that is designated to ensure children or youth are enrolled in school and connected to the appropriate services within the community. **Reminder: failure to comply with federal education assurances may result in Federal sanctions and significantly reduce the likelihood of receiving funding through the CoC Program Competition.**

**The agency acknowledges it will be required to meet the above requirements if it will have any qualifying participants.**

1. Describe how participants will be assisted to obtain and remain in permanent housing.
2. Describe specifically how participants will be assisted both to increase their employment and/or income and to maximize their ability to live independently.
3. For all supportive services available to participants, indicate who will provide them and how often they will be provided.

|  |  |  |
| --- | --- | --- |
| **Supportive Services** | **Provider** | **Frequency** |
| Assessment Of Service Needs | Choose an item. | Choose an item. |
| Assistance With Moving Costs | Choose an item. | Choose an item. |
| Case Management | Choose an item. | Choose an item. |
| Child Care | Choose an item. | Choose an item. |
| Education Services | Choose an item. | Choose an item. |
| Employment Assistance & Job Training | Choose an item. | Choose an item. |
| Food | Choose an item. | Choose an item. |
| Housing Search & Counseling Services | Choose an item. | Choose an item. |
| Legal Services | Choose an item. | Choose an item. |
| Life Skills Training | Choose an item. | Choose an item. |
| Mental Health Services | Choose an item. | Choose an item. |
| Outpatient Health Services | Choose an item. | Choose an item. |
| Substance Abuse Treatment Services | Choose an item. | Choose an item. |
| Transportation | Choose an item. | Choose an item. |
| Utility Deposits | Choose an item. | Choose an item. |

1. Please identify whether the project will include the following activities:
   1. Transportation assistance to clients to attend mainstream benefit appointments, employment training, or jobs? Choose an item.
   2. Regular follow-ups with participants to ensure mainstream benefits are received and renewed? Choose an item.
   3. Will project participants have access to SSI/SSDI technical assistance provided by the agency or partner agency? Choose an item.

# Housing Type and Location

1. Is this housing type and location for the **TH portion or the RRH portion** of the project?
2. Housing type: Choose an item.
3. What is the funding source for these units and beds?
4. Maximum number of units and beds at the selected housing site:
   1. Units:
   2. Beds:
5. Project Address:

Street:

City:

State:

ZIP Code

1. Is this housing type and location for the **TH portion or the RRH portion** of the project?
2. Housing type: Choose an item.
3. What is the funding source for these units and beds?
4. Maximum number of units and beds at the selected housing site:
   1. Units:
   2. Beds:
5. Project Address:

Street:

City:

State:

ZIP Code

# Project Participants - Households

**Households Table**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | Households w/ at least one adult & one child | Adult households w/out children | Households with ONLY children | **Total** |
| Number of Households |  |  |  |  |
|  |  |  |  |  |
| Characteristics | Persons in households with AT LEAST one adult & one child | Adult persons in households w/out children | Persons in households with ONLY children | **Total** |
| Adults over age 24 |  |  |  |  |
| Adults ages 18-24 |  |  |  |  |
| Accompanied children under age 18 |  |  |  |  |
| Unaccompanied children under age 18 |  |  |  |  |
| **Total persons** |  |  |  |  |

# Project Participants – Subpopulations

**Persons in Households with at least one adult and one child**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Characteristics** | Adults over age 24 | Adults ages 18-24 | Children under age 18 | **Total** |
| Chronically Homeless Non-Veterans |  |  |  |  |
| Chronically Homeless Veterans |  |  |  |  |
| Non-Chronically Homeless Veterans |  |  |  |  |
| Chronic Substance Abuse |  |  |  |  |
| Persons With HIV/AIDS |  |  |  |  |
| Severely Mentally Ill |  |  |  |  |
| Victims Of Domestic Violence |  |  |  |  |
| Physical Disability |  |  |  |  |
| Developmental Disability |  |  |  |  |
| Persons Not Represented By Listed Subpopulations |  |  |  |  |
| **Total Persons** |  |  |  |  |

**Persons in Households WITHOUT Children**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Characteristics** | Adults over age 24 | Adults ages 18-24 | Children under age 18 | **Total** |
| Chronically Homeless Non-Veterans |  |  |  |  |
| Chronically Homeless Veterans |  |  |  |  |
| Non-Chronically Homeless Veterans |  |  |  |  |
| Chronic Substance Abuse |  |  |  |  |
| Persons With HIV/AIDS |  |  |  |  |
| Severely Mentally Ill |  |  |  |  |
| Victims Of Domestic Violence |  |  |  |  |
| Physical Disability |  |  |  |  |
| Developmental Disability |  |  |  |  |
| Persons Not Represented By Listed Subpopulations |  |  |  |  |
| **Total Persons** |  |  |  |  |

**Persons in Households with ONLY Children**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Characteristics** | Adults over age 24 | Adults ages 18-24 | Children under age 18 | **Total** |
| Chronically Homeless Non-Veterans |  |  |  |  |
| Chronically Homeless Veterans |  |  |  |  |
| Non-Chronically Homeless Veterans |  |  |  |  |
| Chronic Substance Abuse |  |  |  |  |
| Persons With HIV/AIDS |  |  |  |  |
| Severely Mentally Ill |  |  |  |  |
| Victims Of Domestic Violence |  |  |  |  |
| Physical Disability |  |  |  |  |
| Developmental Disability |  |  |  |  |
| Persons Not Represented By Listed Subpopulations |  |  |  |  |
| **Total Persons** |  |  |  |  |

# Outreach for Participants

1. Enter the percentage of project participants that will be coming from each of the following locations.

|  |  |  |
| --- | --- | --- |
|  |  | Directly from the street or other locations not meant for human habitation. |
|  |  | Directly from emergency shelters. |
|  |  | Persons at imminent risk of losing their night time residence within 14 days, have no subsequent housing identified, and lack the resources to obtain other housing. |
|  |  | Directly from safe havens. |
|  |  | Persons fleeing domestic violence. |
|  |  | Directly from transitional housing. |
|  |  | Persons receiving services through a Department of Veterans Affairs (VA) – funded homeless assistance program (eligible for JOINT projects if from TH or Emergency Shelters). |
|  |  | **Total of above percentages** |

1. Describe the outreach plan to bring these homeless participants into the project.

# Budget

1. What type of CoC funding is this project applying for in the 2018 CoC Competition? Choose an item.
2. Does this project propose to allocate funds according to an indirect cost rate? Choose an item.
   1. Rate:
   2. Method:
3. Select the costs for which funding is being requested:

Leased Units

Leased Structures

Rental Assistance

Supportive Services

Operating

HMIS

1. Will this project generate program income as described in 24 CFR 578.97 that will be used as Match for this grant? Choose an item.
2. Match: *Please note that if you are using more than one source you must provide the information below for each source and submit a separate match letter for each.*
   1. Type of commitment: Choose an item.
   2. Type of source: Choose an item.
   3. Date of written commitment:
   4. Value of written commitment:
3. Complete budget tables for funds requested. See excel workbook titled *FY 2018 New Project Application – Budget Tables*